

## CSEA EMPLOYEE BENEFIT FUND CLAIM FORM

Use this form to claim CSEA Employee Benefit Fund benefits for

Physician Co-Pay Hearing Aid

Prescription Drug Co-Pay Maternity

Phone 800 323-2732

Claim Form must be completed and signed by the CSEA Employee Benefit Fund Member	r.
All required documentation must be attached. Incomplete claims will be returned.	
Mail completed claims to:	

CSEA Employee Benefit Fund P.O. Box 516

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Last	First	Initial		aid Consider	N
	Member Name			ocial Security	
Number & Street	sacy printout attached whe		Village/Town/City Iress		Zip Code
	Membe	er's Home Add	iress		
( )					
Member's Da	ytime Phone Number	Membe	r's Employer	Member's Sig	gnature
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